No. 04-1506

NOV 2 2 2005

In The

Supreme Court of the United States

ARKANSAS DEPARTMENT OF
HEALTH AND HUMAN SERVICES, et al.,

Petitioners,

v.

HEIDI AHLBORN,

Respondent.

**On Writ Of Certiorari To The
United States Court Of Appeals
For The Eighth Circuit**

BRIEF FOR THE PETITIONERS

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QUESTION PRESENTED

Whether federal Medicaid law, which requires that a medical assistance recipient assign to the state any right to payment from a third party that is liable for the recipient's medical expenses, and which also prohibits the placement of a pre-death lien upon a recipient's "property," entitles the state to full reimbursement from personal injury settlement proceeds of Medicaid benefits paid on the recipient's behalf for medical costs caused by the third party, regardless of what portion of the settlement proceeds are designated as compensation for medical care?

PARTIES TO THE PROCEEDING

The parties to the proceeding are:

HEIDI AHLBORN, an individual;

ARKANSAS DEPARTMENT OF HEALTH AND HUMAN SERVICES;[1] JOHN SELIG, Director of the Arkansas Department of Health and Human Services; GLORIA CHUNN, Chief Program Administrator, Division of Medical Services, Arkansas Department of Health and Human Services; ROY JEFFUS, Director of Division of Medical Services, Arkansas Department of Human Services.

[1] Following the filing of the Petition for Writ of Certiorari, several changes occurred regarding the status of the Petitioners: (1) the agency's name changed to Arkansas Department of Health and Human Services; (2) John Selig succeeded Kurt Knickrehm as Director; (3) Gloria Chunn now performs the duties previously performed by Wayne Olive; and (4) Roy Jeffus is now a permanent, as opposed to interim, director.

TABLE OF CONTENTS

	Page
QUESTION PRESENTED FOR REVIEW	i
PARTIES TO THE PROCEEDING	ii
TABLE OF CONTENTS	iii
TABLE OF AUTHORITIES	v
OPINIONS BELOW	1
JURISDICTION	1
STATUTES AND REGULATIONS INVOLVED	1
STATEMENT	5
A. Factual Background	5
B. Federal Statutory and Regulatory Background	10
1. The Medicaid Program In General	10
2. Third Party Assignment And Recovery Provisions (TPL Provisions)	11
3. The "Anti-Lien Provision"	14
C. Arkansas's Compliance with the Act's TPL Provisions	14
D. Procedural History	16
1. The District Court's Decision	16
2. The Court Of Appeals' Decision	19
SUMMARY OF ARGUMENT	21
ARGUMENT	24

TABLE OF CONTENTS – Continued

Page

I. Medicaid's TPL Provisions Mandate Full Reimbursement To The Medicaid Program From Third Party Personal Injury Settlement Proceeds 24

A. The Plain Language Of The Federal TPL Provisions Reflect Congress's Intent To Create A Broad Right Of Reimbursement For The Medicaid Program 26

B. Arkansas's Third Party Assignment And Recovery Laws, Which Were Enacted In Compliance With The Federal TPL Provisions, Do Not Violate The Federal Anti-Lien Provision 32

II. The Secretary's Adjudications And Interpretations Addressing Medicaid, Which Is A "Complex And Highly Technical Regulatory Program," Are Entitled To Deference And Respectful Consideration 36

A. The Departmental Appeals Board's Rulings That The Medicaid Program Is Entitled To Full Reimbursement Are Entitled To *Chevron* Deference 37

B. The Secretary's Interpretations Addressing The Relationship Between The Federal TPL And Anti-Lien Provisions Are Entitled To Respectful Consideration 41

III. Full Reimbursement Of The Medicaid Program Is Preferable From A Policy Standpoint 45

CONCLUSION 49

TABLE OF AUTHORITIES

Page

FEDERAL CASES

Atkins v. Rivera, 477 U.S. 154 (1986) 10

Blue Chip Stamps v. Manor Drug Stores, 421 U.S. 723 (1975) 26

Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837 (1984) 22, 36, 41

Christensen v. Harris County, 529 U.S. 576 (2000) 44

Deal v. United States, 508 U.S. 129 (1993) 35

Ernst & Ernst v. Hochfelder, 425 U.S. 185 (1976) 26

FDA v. Brown & Williamson Tobacco Corp., 529 U.S. 120 (2000) 30, 31

Harris v. McRae, 448 U.S. 297 (1980) 10, 11

Schweiker v. Gray Panthers, 453 U.S. 34 (1981) 10, 11, 24, 25

Skidmore v. Swift & Co., 323 U.S. 134 (1944) 36, 44

Sullivan v. Stroop, 496 U.S. 478 (1990) 26

United States v. Mead Corp., 533 U.S. 218 (2001) 36, 37, 44

Wisconsin Dep't of Health and Family Services v. Blumer, 534 U.S. 473 (2002) ..... *passim*

STATE CASES

Calvanese v. Calvanese, 710 N.E.2d 1079 (N.Y. 1999), *cert. denied*, 528 U.S. 928 (1999) 30, 47

Cricchio v. Pennisi, 683 N.E.2d 301 (N.Y. 1997) 30

Houghton v. Department of Health, 57 P.3d 1067 (Utah 2002), *cert. denied*, 538 U.S. 945 (2003) 30

TABLE OF AUTHORITIES – Continued

Page

Martin v. City of Rochester, 642 N.W.2d 1 (Minn. 2002), *cert. denied*, 539 U.S. 957 (2003) 30

Waterall v. Waterall, 155 S.W.3d 30 (Ark. App. 2005) 35

Wilson v. State, 10 P.3d 1061 (Wash. 2000), *cert. denied*, 532 U.S. 1020 (2001) 30

DECISIONS OF THE DEPARTMENT OF APPEALS BOARD, UNITED STATES DEPARTMENT OF HEALTH & HUMAN SERVICES

California Dep't of Health Services, DAB No. 1504, 1995 WL 66334 (Dep't of Health & Human Services January 5, 1995) 38, 46, 47, 49

Washington State Dep't of Social & Health Services, DAB No. 1561, 1996 WL 157123 (Dep't of Health & Human Services February 7, 1996) 13, 40

FEDERAL STATUTES

28 U.S.C. § 1254(1) 1

42 U.S.C. § 1302 ..... 5, 37

42 U.S.C. §§ 1396-1396v 2

42 U.S.C. § 1396 ..... 5, 10, 11

42 U.S.C. § 1396a ..... *passim*

42 U.S.C. § 1396k ..... *passim*

42 U.S.C. § 1396p 4, 8, 14, 28, 40

TABLE OF AUTHORITIES – Continued

Page

FEDERAL REGULATIONS

42 C.F.R. § 430.0 4

42 C.F.R. § 430.10 ..... 5, 11

42 C.F.R. § 430.35 ..... 4, 11

42 C.F.R. § 433.36. ..... 5, 28

42 C.F.R. § 433.136 12

42 C.F.R. § 433.140 ..... 4, 11

45 C.F.R. § 16.4 ..... 5, 38

STATE STATUTES

Ark. Code Ann. § 20-76-201 14

Ark. Code Ann. § 20-77-301 *et seq.* 14

Ark. Code Ann. § 20-77-301 ..... 15, 16, 33

Ark. Code Ann. § 20-77-302 ..... 15, 33

Ark. Code Ann. § 20-77-303 15

Ark. Code Ann. § 20-77-307 ..... 6, 9, 15, 31, 34

OTHER AUTHORITIES

HCFA letter entitled "Treating Disability Trusts Under Transfer Of Assets, Trust, Estate Recovery, And Third Party Liability Rules – INFORMATION (issued June 6, 1996) 43

HCFA letter entitled "Third Party Liability Relationship to Liens" (issued September 2, 1994) 42

TABLE OF AUTHORITIES – Continued

Page

HCFA letter entitled "State Third Party Liability (TPL) Subrogation Legislation" (issued June 1, 1988) 41

S. Rep. No. 99-146 at 279 (1985), *reprinted in* 1986 U.S.C.C.A.N. 42, 312 ..... 24, 29

OPINIONS BELOW

The court of appeals' opinion (Pet. App. 1-15) is reported at 397 F.3d 620 (8th Cir. 2005). The district court's opinion (Pet. App. 16-31) is reported at 280 F.Supp.2d 881 (E.D. Ark. 2003).

JURISDICTION

The judgment of the court of appeals was entered on February 9, 2005 (Pet. App. 1-15). The petition for a writ of certiorari was filed on May 11, 2005, and was granted on September 27, 2005. This Court has jurisdiction under 28 U.S.C. § 1254(1).

STATUTES AND REGULATIONS INVOLVED

42 U.S.C. § 1396a

(a) Contents. A State plan for medical assistance must –

. . .

(25) provide –

(A) that the State or local agency administering such plan will take all reasonable measures to ascertain the legal liability of third parties (including health insurers, group health plans (as defined in section 1167(1) of Title 29), service benefit plans, and health maintenance organizations) to pay for care and services under the plan.

. . .

(B) that in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual and where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery, the State or local agency will seek reimbursement for such assistance to the extent of such legal liability;

. . .

(H) that to the extent that payment has been made under the State plan for medical assistance in any case where a third party has a legal liability to make payment for such assistance, the State has in effect laws under which, to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual, the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services;

42 U.S.C. § 1396k

(a) For the purpose of assisting in the collection of medical support payments and other payments for medical care owed to recipients of medical assistance under the State plan approved under this subchapter [42 U.S.C. §§ 1396-1396v], a State plan for medical assistance shall –

(1) provide that, as a condition of eligibility for medical assistance under the State plan to

an individual who has the legal capacity to execute an assignment for himself, the individual is required –

(A) to assign the State any rights, of the individual or of any other person who is eligible for medical assistance under this subchapter and on whose behalf the individual has the legal authority to execute an assignment of such rights, to support (specified as support for the purpose of medical care by a court or administrative order) and to payment for medical care from any third party.

. . .

(C) to cooperate with the State in identifying, and providing information to assist the State in pursuing, any third party who may be liable to pay for care and services available under the plan

. . .

(b) Such part of any amount collected by the State under an assignment made under the provisions of this section shall be retained by the State as is necessary to reimburse it for medical assistance payments made on behalf of an individual with respect to whom such assignment was executed (with appropriate reimbursement of the Federal Government to the extent of its participation in the financing of such medical assistance), and the remainder of such amount collected shall be paid to such individual.

42 U.S.C. § 1396p

(a) **Imposition of lien against property of an individual on account of medical assistance rendered to him under a State plan.**

(1) No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan.

Arkansas Code Annotated § 20-77-307

(a) As a condition of eligibility, every Medicaid applicant shall automatically assign his or her right to any settlement, judgment, or award which may be obtained against any third party to the Department of Human Services to the full extent of any amount which may be paid by Medicaid for the benefits of the applicant.

(b) The application for Medicaid benefits shall, in itself, constitute an assignment by operation of law.

(c) The assignment shall be considered a statutory lien on any settlement, judgment, or award received by the recipient from a third party.

The following statutes and regulations are reproduced in the appendix to the petition for a writ of certiorari:

42 U.S.C. § 1382b(a), Pet. App. 32-36.

42 C.F.R. § 430.0, Pet. App. 36.

42 C.F.R. § 430.35, Pet. App. 36-37.

42 C.F.R. § 433.140(a)(1), Pet. App. 37.

42 C.F.R. § 447.302, Pet. App. 37.

Ark. Code Ann. § 20-76-201(1), Pet. App. 37.

Ark. Code Ann. §§ 20-77-301 through 20-77-307, Pet. App. 38-43.

The following are reproduced in the appendix to the Brief for the Petitioners:

42 U.S.C. § 1396 (2000), 1a

42 U.S.C. § 1302(a) (2000), 1a

42 C.F.R. § 430.10 (2005), 1a

42 C.F.R. § 433.36(a)-(b) (2005), 2a

45 C.F.R. § 16.4 (2005), 3a

STATEMENT

A. Factual Background

Heidi Ahlborn was involved in a motor vehicle accident in January of 1996. J.A. 4, 22, 42. As a result, she suffered severe injuries that required extensive medical care. *Id.* During her medical treatment, Ahlborn received medical benefits under the Arkansas Medicaid program, which is administered by the Arkansas Department of Health and Human Services ("Department"). *Id.* Ahlborn accrued bills for accident-related medical services of approximately $320,000.00, which costs were billed to the Department. J.A. 22, 42. The Arkansas Medicaid program paid Ahlborn's health care providers approximately $215,645.30 for accident-related medical costs, which fully extinguished Ahlborn's financial obligation. J.A. 22, 24, 42.

As a condition of her eligibility for Medicaid benefits, Arkansas law required that Ahlborn assign to the Department her "right to any settlement, judgment, or award" that she might receive from third parties liable for the medical costs resulting from the accident "to the full extent of any amount which may be paid by Medicaid." J.A. 6, 7 (*citing* Ark. Code Ann. § 20-77-307). The State had enacted this assignment provision in compliance with a mandate under federal Medicaid law that requires participating states to have such an assignment in effect. J.A. 14, Pet. App. 8.

The Department sent Ahlborn a questionnaire seeking information about the accident, her insurance status, and whether she had retained an attorney. Mem. In Supp. Of Defs.' Mot. For Summ. J., Ex. 4 and Olive Aff. at ¶ 7. Ahlborn responded, identifying her attorney as John Casteel. *Id.* The Department then sent Casteel two letters in which it notified him of the State Medicaid program's right to reimbursement from any settlement, judgment, or award obtained against any third party liable for Ahlborn's injuries "to the extent of any amount which may be paid by Medicaid for the benefit of the applicant." Mem. In Supp. Of Defs.' Mot. For Summ. J., Exs. 5, 6 and Olive Aff. at ¶ 10. The letters also notified Casteel that no judgment, award, or settlement may be satisfied "without first giving the [D]epartment notice and a reasonable opportunity to establish its interest." *Id.*

Subsequently, on April 11, 1997, Ahlborn filed a personal injury lawsuit in state circuit court without notifying the Department. J.A. 23, 42. In July of 1997, Ahlborn notified the Department that she had received a $25,000.00 policy limit recovery from one tortfeasor. J.A. 23, 42. On three occasions, Ahlborn requested that the

Department waive its Medicaid claim with regard to this recovery, which the Department refused to do. *Id.*

In December of 1997, Ahlborn notified the Department that she had received a $25,000.00 recovery from her uninsured motorists ("UIM") policy, asserting that the recovery was not subject to the Medicaid claim. *Id.*[2] When the Department disagreed, Ahlborn notified it on January 27, 1998, that it had 20 days to assert a claim against the UIM recovery. J.A. 24, 42. The Department (and Casteel) then intervened in the pending lawsuit. *Id.* In May of 1998, the circuit court entered an order directing Ahlborn to hold the UIM recovery in trust pending resolution of her dispute with the Department and Casteel. J.A. 24, 42; Mem. In Supp. Of Defs.' Mot. For Summ. J., Ex. 18.

Ahlborn estimated that her damages from the accident totaled approximately $3,040,708.12, which included medical care, loss of earnings and work time, pain and suffering, and permanent impairment of ability to earn in the future. J.A. 6, 18. Despite inquiries from the Department and its intervention into the lawsuit, Ahlborn reached a compromise settlement with a remaining tortfeasor without notifying the Department of the ongoing negotiations or involving it in the settlement, thus making her total recovery $550,000.00. J.A. 22-23, 24, 42.[3]

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[2] By this stage in the litigation, Ahlborn had retained her present attorneys, H. David Blair and Phillip Farris, in place of John Casteel. J.A. 23; Mem. In Supp. Of Defs.' Mot. For Summ. J., Exs. 8, 10.

[3] This total settlement consisted of: (a) $25,000.00 from Ahlborn's UIM coverage; (b) $25,000.00 recovery representing the policy limit of one tortfeasor; and (c) $500,000.00 from a second tortfeasor. J.A. 16, 18, 42. There was no allocation of the settlement proceeds among the various damages that Ahlborn alleged in her complaint. J.A. 44-45, 49.

The Department asserted a "claim or lien" in the amount of $219,156.78 against the settlement proceeds – which amount was later reduced to $215,645.30 – to reimburse the Arkansas Medicaid program for medical costs paid to or on behalf of Ahlborn as a result of her involvement in the auto accident. J.A. 5, 11, 18.[4]

Ahlborn subsequently brought suit against the Department and several of its officials in the United States District Court for the Eastern District of Arkansas seeking a declaratory judgment. J.A. 3-9. In her lawsuit, Ahlborn argued that the Arkansas Medicaid program was not entitled to full reimbursement from the settlement proceeds for the amount of medical costs that it had paid on her behalf for injuries resulting from the accident. J.A. 5-7. Specifically, she contended that the Medicaid program was not entitled to reimbursement "to the extent it seeks to reach that portion of [her] settlement other than that attributable to medical expenses furnished by Defendant Department." J.A. 7.

Ahlborn based this argument on a provision of federal Medicaid law that is often called the "anti-lien provision," which prohibits the imposition of a lien "against the property of any individual prior to [her] death on account of medical assistance paid or to be paid on [her] behalf" by a State Medicaid program. J.A. 5-6 (*citing* 42 U.S.C. § 1396p). Ahlborn contended that any portion of the settlement proceeds representing compensation for damages other than medical care (e.g., pain and suffering, lost

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[4] As the district court recognized, the slight discrepancies in these amounts reflect adjustments made to exclude Medicaid payments made on Ahlborn's behalf for medical care unrelated to injuries that she sustained in the auto accident. (Pet. App. 18, n.2).

income, etc.) was her "property," and that the federal anti-lien provision thus preempted Arkansas law to the extent that it authorized medical cost reimbursement from any portion of the settlement proceeds that are not "attributable to medical expenses." J.A. 5-7, 17-18.

In response, the Department contended that the amount of settlement proceeds necessary to fully reimburse the Arkansas Medicaid program for medical costs that it paid on behalf of Ahlborn as a result of her accident was not Ahlborn's "property" because she had assigned her interest in those funds to the Department. J.A. 12-13. The Department reasoned that Arkansas's assignment and recovery laws, which provide in part that as a condition of Medicaid eligibility an applicant "shall automatically assign his or her right to any settlement, judgment, or award which may be obtained against any third party to the Department . . . to the full extent of any amount which may be paid by Medicaid for the benefit of the applicant," were enacted in compliance with 42 U.S.C. § 1396a(a)(25), which mandates that Medicaid-participating states (such as Arkansas) effectuate laws under which the State is considered to have acquired a recipient's right to payment by any liable party "to the extent that payment has been made under the State plan for medical assistance." J.A. 12-13, 17-18, Pet. App. 42 (Ark. Code Ann. § 20-77-307(a)).

Because Ahlborn and the third parties with whom she settled did not allocate the settlement proceeds among her various claims, the Department and Ahlborn stipulated to an allocation in order to enable the federal court to rule on the statutory construction issue as a matter of law. J.A. 18-19, 44-45, 49. The parties clarified, however, that the stipulation "in no way affect[ed] the relative position of the

parties as regards the statutory construction issue." J.A. 19.

Adopting the Department's reasoning, the district court held that the federal anti-lien provision did not prevent full reimbursement of the State Medicaid program from the settlement proceeds. Pet. App. 29, 30. The court of appeals overturned this ruling, finding that settlement monies representing compensation for elements other than medical care were Ahlborn's "property" protected by the anti-lien provision. Pet. App. 14.

B. Federal Statutory And Regulatory Background

1. The Medicaid Program In General

Enacted in 1965 as Title XIX of the Social Security Act ("Act"), Medicaid is a publicly funded program designed to pay medical costs for individuals whose income and resources are insufficient to meet the cost of medical care and services that they need. *Atkins v. Rivera*, 477 U.S. 154, 156 (1986) (citations omitted); 42 U.S.C. § 1396 (2000). The primary purpose of the Medicaid program is to provide federal financial assistance to states that elect to reimburse certain costs of medical treatment for needy individuals. *Harris v. McRae*, 448 U.S. 297, 301 (1980). Congress intended Medicaid to be "the payer of last resort, that is, other available resources must be used before Medicaid pays for the care of an individual enrolled in the Medicaid program." S. Rep. No. 99-146 at 279 (1985), *reprinted in* 1986 U.S.C.C.A.N. 42, 312, Pet. App. 44. The common sense policy underlying this intent is evident, considering that "[t]here are limited resources to spend on welfare." *Schweiker v. Gray Panthers*, 453 U.S. 34, 48 (1981).

Although participation in the Medicaid program is entirely optional, once a State such as Arkansas chooses to participate it must comply with the requirements of the Act itself, as well as with those imposed by the United States Secretary of Health and Human Services. ("Secretary"). *Harris*, 448 U.S. at 301; *Schweiker*, 453 U.S. at 37-38. The Centers for Medicare and Medicaid Services ("CMS"),[5] which is a branch of the federal Department of Health and Human Services, administers the Medicaid program federally. *See Wisconsin Dept. of Health & Family Servs. v. Blumer*, 534 U.S. 472, 478 n.1 (2002). Each participating state must develop a "State plan" that comprehensively describes the nature and scope of its Medicaid program, and that provides assurances that the program will be administered in conformity with the Act, regulations promulgated thereunder by the Secretary, and other "applicable official issuances" of the federal Department of Health and Human Services. 42 C.F.R. § 430.10 (2005); *see generally* 42 U.S.C. §§ 1396, 1396a (2000). The federal government may penalize a state's non-compliance by a reduction in or the complete withholding of federal funding to the state. 42 C.F.R. §§ 430.35(a)(1) (2005); *see also* 42 C.F.R. § 433.140(a)(1) (2005) (applies specifically to state's failure to seek reimbursement from liable third party).

2. Third Party Assignment and Recovery Provisions ("TPL" Provisions)

The Act does not authorize the federal government to recover Medicaid expenditures directly from third parties.

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[5] CMS was previously known as the Health Care Financing Administration, or "HCFA."

Instead, it protects the federal fisc by explicitly requiring participating states to pursue reimbursement of state and federal medical assistance payments when third parties[6] are responsible for the injuries underlying those expenses. Once a state receives this reimbursement, the Act requires that it return to CMS the federal portion of the payments.

Specifically, federal law requires that states take "all reasonable measures to ascertain the legal liability of third parties . . . to pay for care and services under the plan." 42 U.S.C. § 1396a(a)(25)(A) (2000). "In cases where such a legal liability is found to exist after medical assistance has been made available on behalf of the [recipient]," the state must "seek reimbursement for such assistance *to the extent of such liability*." 42 U.S.C. § 1396a(a)(25)(B) (2000) (emphasis added). The Act mandates that states enact laws in furtherance of this goal; specifically,

> In any case where a third party has a legal liability to make payment for [medical] assistance, the State has in effect laws under which, *to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual*, the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services.

42 U.S.C. § 1396a(a)(25)(H) (2000) (emphasis added). Likewise, the Act mandates that each state require Medicaid applicants, as a condition of eligibility, to assign to the state their right to payment for medical care from any

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[6] 42 C.F.R. § 433.136 defines a "third party" as "any individual, entity or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a State plan."

liable third party. 42 U.S.C. § 1396k(a)(1)(A) (2000). A Medicaid recipient also has a duty to "cooperate" with the State "in identifying, and providing information to assist the state in pursuing, any third party who may be liable to pay for care and services available under the plan." 42 U.S.C. § 1396k(a)(1)(C) (2000).

The Act's TPL provisions expressly require the State Medicaid program be reimbursed from third party recoveries before the recipient may receive any remaining amount.[7] Specifically, 42 U.S.C. § 1396k(b) requires:

> [s]uch part of any amount collected by the State under an assignment . . . shall be retained by the State *as is necessary to reimburse it for medical assistance payments made on behalf of an individual* with respect to whom such assignment was executed (with appropriate reimbursement of the Federal Government to the extent of its participation in the financing of such medical assistance), and the remainder of such amount collected shall be paid to such individual.

42 U.S.C. § 1396k(b) (2000) (emphasis added).

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[7] Reasonable litigation expenses and attorney fees are payable from a recovery, however, prior to reimbursement of the Medicaid program if the recipient brings an action against a potentially liable third party. *See* Ark. Code Ann. § 20-77-302 (after payment of reasonable expenses and attorney's fees, the Department shall "receive an amount sufficient to reimburse the [D]epartment the full amount of benefits paid on behalf of the recipient under the medical assistance program"); *Washington State Dep't of Social & Health Services*, DAB No. 1561, 1996 WL 157123 (Dep't of Health & Human Services February 7, 1996), Pet. App. 45, 64-67 (finding appropriate a state law authorizing recovery of attorney's fees and costs "prior to reimbursement of the Medicaid program").

3. The "Anti-Lien Provision"

A separate provision of the Act, which is commonly referred to as the "anti-lien provision," protects a Medicaid recipient's "property" during her lifetime from liens related to medical expenditures made under the Medicaid program. 42 U.S.C. § 1396p(a)(1) (2000). In relevant part, this provision provides that "[n]o lien may be imposed against the property of any individual prior to [her] death on account of medical assistance paid or to be paid on [her] behalf under the State plan." *Id.* The parties in the present case agree that the Act's TPL provisions allow the State Medicaid program to recover some portion of the accident-related medical costs that it paid on Ahlborn's behalf, even in view of the anti-lien provision. They disagree as to the reach of the recovery and assignment provisions, however, and thus to what extent the State Medicaid program may seek reimbursement from the compromise settlement proceeds without running afoul of the anti-lien provision.

C. Arkansas's Compliance With The Act's TPL Provisions

Arkansas participates in the federal Medicaid program and has designated the Arkansas Department of Health and Human Services as the State agency responsible for administrating the State plan. *See* Ark. Code Ann. § 20-76-201(1) (2001). In compliance with the Act, Arkansas enacted laws under which the Department acquires the right of a Medicaid recipient to receive payments from liable third parties who caused the recipient's need for medical care expenditures. *See generally* Ark. Code Ann. § 20-77-301 through 20-77-307 (2001) (providing assignment and recovery mechanism).

As required by the federal TPL provisions, Arkansas law mandates that Medicaid recipients, as a condition of eligibility for benefits, assign to the Department their right to certain payments from liable third parties. Arkansas's assignment and recovery provisions provide in part:

> (a) As a condition of eligibility, every Medicaid applicant shall automatically assign his or her right to any settlement, judgment, or award which may be obtained against any third party to the [State] Department of Human Services to the full extent of any amount which may be paid by Medicaid for the benefit of the applicant.
>
> (b) The application for Medicaid benefits shall, in itself, constitute an assignment by operation of law.
>
> (c) The assignment shall be considered a statutory lien on any settlement, judgment, or award received by the recipient from a third party.

Ark. Code Ann. § 20-77-307(a)-(c) (2001). The law provides for three means through which recovery from a liable third party for medical assistance costs paid to the recipient can be realized: (1) the recipient may bring an action alone and reimburse the State program, (2) the Department may bring an action on its own, or (3) the recipient and Department may prosecute an action together. Ark. Code Ann. §§ 20-77-301, 302, 303 (2001). In no event, however, may an action by the Department operate as a bar "to any action upon the claim or cause of action of the recipient," nor shall it deny to the recipient recovery for damages beyond the medical assistance benefits provided by the

State Medicaid program. Ark. Code Ann. § 20-77-301(b) (2001).

D. Procedural History

1. The District Court's Decision

The Department and Ahlborn filed cross motions for summary judgment in the United States District Court for the Eastern District of Arkansas. Pet. App. 16. The parties agreed that the issue in the case – the extent to which the State could recover Medicaid benefits that it had paid on Ahlborn's behalf from a personal injury lawsuit settlement – was an issue of statutory construction for the Court. *Id.* In a Judgment entered August 22, 2003, the district court granted summary judgment in favor of the Department, holding that "the Medicaid statute is intended to vest States with the right to recover the full payment of medical expenses by a third party liable for causing the injuries which triggered the need for medical care." Pet. App. 30.

As an initial matter, the district court recognized that federal Medicaid statutes were enacted as part of a publicly funded program to provide medical care to individuals lacking the resources to obtain essential medical services, and that the Medicaid program was intended to be the "payer of last resort." Pet. App. 19. It likewise noted that the State of Arkansas, which subjected itself to compliance with the mandates of the Act and regulations promulgated thereunder by voluntarily electing to participate in this program, enacted its assignment and recovery statute in compliance with the federal mandate set forth in 42 U.S.C. § 1396k. Pet. App. 20-21. The court then rejected Ahlborn's argument that the Act's anti-lien provision limited the

Department's right to full reimbursement from the settlement proceeds.

First, the court reasoned that personal injury settlement proceeds that a Medicaid applicant assigns to the Department as a condition of eligibility for Medicaid benefits is not the "property" of the Medicaid beneficiary within the meaning of the anti-lien provision. Pet. App. 22, 23, 30. Adopting the reasoning of the highest courts of Utah and Washington, as well as the dissenting opinion joined by three of the seven justices of the highest court in Minnesota, the district court found that "the anti-lien provision drops out of the analysis" following an assignment because a Medicaid recipient "no longer has an interest in the property (his or her action against third parties) to the extent of the state's expenditures." Pet. App. 26 (citations omitted).

Next, the district court recognized that the United States Department of Health and Human Services, the federal agency charged with administering the Medicaid laws in question, had consistently interpreted the Act in the same manner as the State of Arkansas. Pet. App. 27. Specifically, the court noted that the Secretary, which "has not hesitated to enforce its position against participating States," has taken the position that "States must require, as a condition of eligibility, that recipients assign to the State their right to recover from third parties and that, from any such recovery, the State must recover the full amount of benefits paid on the behalf of the recipient." *Id.* (citations omitted). In finding the Secretary's position entitled to "due consideration," the district court cited to cases in which this Court has recognized the Secretary's "significant expertise" in the context of this "complex and highly technical regulatory program," and has granted the

Secretary "exceptionally broad authority" under the Medicaid statute. Pet. App. 28 (citations omitted).

Finally, the district court recognized that if Ahlborn's lawsuit had been litigated to conclusion or reduced to a sum certain at the time that she had applied for Medicaid benefits, she would have been forced to expend those monies, or "resources," before she would have qualified for Medicaid benefits. *Id.* The district court thus concluded that a Medicaid applicant's unliquidated tort claim is both a "resource" and "property" for purposes of the Medicaid Act, and consequently, "there is nothing incongruent about requiring an applicant, as a condition of Medicaid eligibility, to assign to the State his entire 'rights to payment from third parties.'" Pet. App. 29.

Summarizing its reasoning in support of the Department's interpretation of the Act, the district court explained:

> Section 1396a(a)(25), which [Ahlborn] construes as limiting Arkansas' right of assignment, is harmonized with the remainder of the Medicaid statute by a broader reading. The Medicaid statute requires States to ascertain the "legal liability" of third parties "to pay for care and services" rendered under the Medicaid program, 42 U.S.C. § 1396a(a)(25)(A), and, to pursue recovery to the full "*extent of such legal liability*," 42 U.S.C. § 1396a(a)(25)(B) [district court's emphasis]. Full effect to the statute as a whole is supported by an interpretation of the statutory provisions that does not limit States to the compromise value assigned to the medical expenses component of the assigned claim during settlement negotiations . . . [a]lthough the statutory language in question is far from a model of clarity, when the Court

> considers the statute as a whole, the Secretary's position on the issue, and the legislative history of the Medicaid statute . . . it concludes that the [Department] ha[s] the better argument. The Medicaid statute is intended to vest States with the right to recover the full payment of medical expenses by a third party liable for causing the injuries which triggered the need for medical care.

Pet. App. 29-30.

2. The Court Of Appeals' Decision

A panel of the United States Court of Appeals for the Eighth Circuit reversed, finding that "Ahlborn ha[d] the better of the argument." Pet. App. 2. Like the district court, the court of appeals recognized that Congress intended Medicaid to be a "payer of last resort," and that the "primary purpose of the [Medicaid] program is to provide federal financial assistance to States that elect to reimburse certain costs of medical treatment for needy individuals." Pet. App. 4 (citations omitted). Contrary to the district court, however, the court of appeals found that Ahlborn's unliquidated tort claim remained her "property," and that the federal anti-lien provision thus preempted Arkansas's assignment and recovery provisions "to the extent that they require Ahlborn to assign her rights to recover third-party liability payments for matters other than the cost of her medical care and services." Pet. App. 14.

In so ruling, the court of appeals found that the Arkansas law "requires recoupment from, and places a lien on, the entirety of third-party payments – not just that portion of the third-party payment for medical care."

Pet. App. 5. The court rejected the Department's argument that State law did not conflict with the federal anti-lien provision because the federal TPL provisions *mandate* that Medicaid participating states impose such a reimbursement mechanism. Pet. App. 5-6. Turning to 42 U.S.C. § 1396a(25)(H) and 42 U.S.C. § 1396k(a)(1), the court reasoned that the Act mandates only that participating states recover payments made by third parties "to compensate for medical care." Pet. App. 10. The court explained:

> [w]e believe a straightforward interpretation of the text of these statutes demonstrates that the federal statutory scheme requires only that the State recover payments from third parties to the extent of their legal liability to compensate the beneficiary *for medical care and services* incurred by the beneficiary. Under § 1396a(a)(25)(H), a state Medicaid plan must include provisions specifying that, when the State provides medical benefits to an applicant, "the State is considered to have acquired the rights of such individual to *payment by any other party for such health care items or services.*" [court's emphasis]. The acquisition of rights occurs only in cases where a "third party has a legal liability to make payment for [medical] assistance." *Id.* Section 1396k(a)(1)(A) similarly requires that an applicant assign to the State her right "to *payment for medical care* from any third party." [court's emphasis]. Both statutes are thus limited to rights to third-party payments made to compensate for medical care.

Pet. App. 9-10. The court likewise refused to defer to the Secretary's interpretation of the federal third-party liability provisions, finding deference unwarranted because the

Secretary's interpretation was "inconsistent with the plain language of the [Act]." Pet. App. 11.

Finally, the court found that Ahlborn's unliquidated cause of action was not a "resource" that should have been considered in determining her Medicaid eligibility. Pet. App. 7 & n.1. Finding that Ahlborn lacked the power to convert her cause of action to cash when she applied for Medicaid benefits, it concluded that "although the same cause of action was property; . . . it was not a resource." Pet. App. 7 & n.1, 8 (citation and internal quotations omitted).

SUMMARY OF ARGUMENT

I. The plain language of the federal TPL provisions reflect Congress's unambiguously expressed intent that Medicaid be a "payer of last resort." In summary, they mandate that Medicaid-participating states seek Medicaid reimbursement from legally liable third parties "to the extent of such legal liability," enact laws under which they acquire the rights of the Medicaid recipient to payment by liable third parties "to the extent that payment has been made under the State [Medicaid] plan," and require Medicaid applicants "as a condition of eligibility" to assign to the State any rights to "payment for medical care from liable third parties." The federal TPL provisions establish a priority in favor of full Medicaid reimbursement, mandating that states retain any amount collected pursuant to the pre-eligibility assignment "as is necessary to reimburse it for medical assistance payments made on behalf of the recipient," before any remaining amount be paid to the recipient. Through these provisions, Congress effectively shifted a recipient's medical care costs from the State

Medicaid programs and taxpaying public to the third parties who triggered those costs.

In compliance with these federal mandates, Arkansas enacted laws requiring Medicaid applicants to assign to the Department as a condition of eligibility "his or her right to any settlement, judgment, or award" obtained against a third party "to the full extent of any amount which may be paid by Medicaid for the benefit of the applicant." State law also provides that the assignment shall be considered a statutory lien on any settlement, judgment, or award received from the third party. Because the scope of the assignment under Arkansas law does not exceed the scope mandated by federal law, the court of appeals erred in holding that State law was "preempted" by the federal anti-lien provision. Furthermore, because any property that Ahlborn assigned as a condition of Medicaid eligibility was no longer her "property," Arkansas law did not violate the federal anti-lien provision by placing a statutory lien on any recovery that fell within the scope of the federally-mandated assignment.

II. Any arguable ambiguity as to the breadth of the federal TPL provisions and their relationship to the federal anti-lien provision has been resolved by the United States Secretary of Health and Human Services, to whom this Court recognized Congress delegated "extremely broad regulatory authority . . . in the Medicaid area." Adjudications by Health and Human Services's Departmental Appeals Board, which are entitled to *Chevron* deference, twice confirmed the broad reach of the federal TPL provisions, rejecting state schemes that allowed recipients to keep some portion of third party settlement recoveries prior to full Medicaid reimbursement.

In well-reasoned letters to the states, the Secretary (through HCFA/CMS) has confirmed that the anti-lien provision does not prohibit states from placing liens on third party settlement proceeds. Although these more informal interpretations are not entitled to the same degree of deference as agency adjudications, this Court has long recognized that informal policy interpretations by an agency charged with the administration of a statute are entitled to some level of deference as long as they are informed, reasonable, and persuasive.

III. Sound policy likewise favors full Medicaid reimbursement from settlement proceeds. First, had Ahlborn not applied for Medicaid benefits but rather had she been billed directly by health care providers, she would have been responsible to pay all of her medical bills from the third party settlement proceeds. In enacting the TPL statutes, Congress certainly did not intend to place Medicaid in a less favorable position than a for-profit provider.

Second, it is incongruous to argue on one hand that Ahlborn's resources were so limited at the time of her accident that she qualified for publicly funded medical benefits for the "needy," but on the other hand that she retained a property interest – insulated from the federal TPL reimbursement mandate – in those portions of a personal injury settlement that she and a third party designate as or consider to be something other than recovery for medical care.

Third, Ahlborn's position would force states to intervene into all ongoing litigation or to file independent causes of action against all third party tortfeasors in order to recover Medicaid program expenditures, which would

result in a substantial increase in expenditures of state resources. Requiring states to pursue third parties directly to recover publicly funded medical costs, instead of using lien or subrogation statutes to do so, would force states to spend much more money to recover the same amount of funds, thereby leaving less money to return to the Medicaid program for use by Medicaid applicants in need.

Finally, Ahlborn's approach would promote manipulation in the apportionment of settlement recoveries by the recipient and tortfeasor, in whose interest it would be to lessen the amount of any settlement allocated to medical costs and thereby to reduce the amount owed to Medicaid notwithstanding the amount actually paid out by Medicaid for the patient's care.

ARGUMENT

I. Medicaid's TPL Provisions Mandate Full Reimbursement To The Medicaid Program From Third Party Personal Injury Settlement Proceeds

Congress intended that Medicaid be "the payer of last resort, that is, other available resources must be used before Medicaid pays for the care of an individual enrolled in the Medicaid program." S. Rep. No. 99-146 at 279 (1985), *reprinted in* 1986 U.S.C.C.A.N. 42, 312; Pet. App. 44. Sound fiscal and societal considerations support this intent, such as ensuring that sufficient funds remain in the program for future Medicaid recipients and lessening the burden on state and federal taxpayers. As this Court recognized in *Schweiker v. Gray Panthers*, "[t]here are

limited resources to spend on welfare." 453 U.S. 34, 48 (1981).

Congress advanced this objective through Medicaid's TPL provisions, which require participating states to enact legislation under which the State Medicaid program acquires the rights of recipients to payment for medical costs when a third party caused and is legally liable for those expenses "to the extent that payment has been made under the State plan for medical assistance." 42 U.S.C. § 1396a(a)(25)(H). Through these statutes, Congress effectively shifted a recipient's medical care costs from the Medicaid program and taxpaying public to third parties who caused the recipient's injuries, thereby conserving program funds for other people who do not have sufficient income and resources to pay for needed medical care.

In the present case, the parties agree that the federal recovery and assignment statutes, as well as Arkansas law enacted in compliance with them, permit the State Medicaid program to recover some portion of Ahlborn's settlement proceeds. Their disagreement lies in whether the federal anti-lien provision limits program reimbursement to that portion of the settlement proceeds that the recipient and liable third party designate as recovery for "medical costs." Stated differently, while the Department argues that the federal TPL provisions contemplate that the Medicaid program be fully reimbursed for medical costs that it paid on Ahlborn's behalf that were caused by the third party with whom she settled (without the Department's participation or agreement), Ahlborn argues that any portion of the compromise settlement that represents recovery for her non-medical claims (e.g., pain and suffering) is her "property" protected by the anti-lien provision.

Nothing in the statutory text speaks directly to how the federal TPL provisions operate in the context of a compromise settlement. Both the plain language of these statutes and Congress's expressed intent that Medicaid be the "payer of last resort," however, lead to the inescapable conclusion that the Medicaid program is to be reimbursed in full from the settlement proceeds for the entire amount of medical costs that were caused by the third party. Nothing in the language of the anti-lien provision supports Ahlborn's contention, which in effect would force the Medicaid program to accept a compromised value for its medical payments claim merely because Ahlborn chose to accept a compromise value for the remainder of her claim – a claim that she valued at nearly three million dollars.

A. The Plain Language Of The Federal TPL Provisions Reflect Congress's Intent To Create A Broad Right Of Reimbursement For The Medicaid Program

"The starting point in every case involving construction of a statute is the language itself." *Ernst & Ernst v. Hochfelder*, 425 U.S. 185, 197 (1976) (*quoting Blue Chip Stamps v. Manor Drug Stores*, 421 U.S. 723, 756 (1975) (Powell, J., concurring)). If the language of the statute is plain and unambiguous, the inquiry is at its end, "for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress." *Sullivan v. Stroop*, 496 U.S. 478, 482 (1990) (citation omitted). In the present case, the plain language of the federal TPL provisions instruct that when a third party is liable for a Medicaid recipient's medical expenses, the Medicaid program must be fully reimbursed for medical assistance payments made on behalf of the recipient before the

recipient may receive any remaining payment. There is nothing in the language of these statutes, nor in the anti-lien provision, that reflects a Congressional intent to limit the broad reach of the Medicaid program's recovery right.

Congress mandated in 42 U.S.C. § 1396a that states will "take all reasonable measures to ascertain the legal liability of third parties . . . to pay for care and services under the plan." 42 U.S.C. § 1396a(a)(25)(A). If such liability exists, states must "seek reimbursement [from the third party] for such assistance *to the extent of such legal liability.*" 42 U.S.C. § 1396a(a)(25)(B) (emphasis added). In furtherance of this recovery goal, the statute requires that states enact laws "under which, *to the extent that payment has been made* under the State plan for medical assistance for health care items or services furnished to an individual," the "State is considered to have acquired the rights" of the recipient to third party payments for these items or services." 42 U.S.C. § 1396a(a)(25)(H).

Likewise, Congress mandated that "[f]or the purpose of assisting in the collection of . . . payments for medical care owed to recipients of medical assistance," that State plans must provide that, "as a condition of eligibility for medical assistance under the State plan," a Medicaid applicant (or other person who has the legal capacity to execute an assignment on her behalf) "assign to the State any rights . . . to payment for medical care from any third party." 42 U.S.C. § 1396k(a) and (a)(1)(A). The statute likewise obligates Medicaid recipients to "assist the State in identifying, and providing information to assist the State in pursuing, any third party who may be liable to pay for care and services available under the plan." 42 U.S.C. § 1396k(a)(1)(C). Congress also established a payment priority in favor of the Medicaid program, instructing that

any amount collected pursuant to the assignment "shall be retained by the State *as is necessary to reimburse it for medical assistance payments made on behalf of the individual*," instructing that any remaining amount be paid to the recipient. 42 U.S.C. § 1396k(b).

In reading these TPL provisions together, one must conclude from their plain language that Congress intended to structure a mechanism whereby the Medicaid program would become entitled to payment for all medical costs from a third party who caused those expenses that the recipient could have recovered had she paid for the medical services herself. Such a reading not only is reasonable, but is consistent with Congress's intention that Medicaid be "the payer of last resort." Furthermore, nothing in the anti-lien statute suggests that Congress intended that Medicaid's broad recovery rights set forth in the TPL provisions be narrowed within the context of a compromise settlement.

The anti-lien provision, in relevant part, provides that "[n]o lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State [Medicaid] plan." 42 U.S.C. § 1396p(a)(1). Although Congress did not define the term "property," the Secretary did so in a regulation that applies to both 42 U.S.C. §§ 1396a and 1396p, as "the homestead of and all other personal and real property in which a recipient has a legal interest." 42 C.F.R. § 433.36(b) (2005). This definition lends no support to Ahlborn's argument that the anti-lien provision insulates that portion of a settlement that the recipient and third party designates as (or deems to be) recovery for something other than medical care from the reach of the federal TPL statutes.

It is highly unlikely that Congress intended "property" to have such a definition considering the legislative history, which shows a consistent trend toward strengthening the TPL provisions but contains no hint that the anti-lien provision insulates any portion of settlement proceeds from liable third parties from Medicaid reimbursement. A requirement that states identify third parties that might be liable to pay for a recipient's medical assistance was first added to the Act in 1968. *See* P.L. 90-248, § 229 (adding new subsection to Section 1902(a) of the Act [42 U.S.C. § 1396a(a)]). In 1977, Congress enhanced the ability of states to identify and collect from liable third parties by affording states *permission* to require an assignment as a condition of eligibility. *See* P.L. 142, § 12(b) (adding new Section 1912 to the Act [42 U.S.C. § 1396k]). Congress made this permissive assignment mandatory in 1984. *See* P.L. 98-369, § 2367(a) (adding new subsection to Section 1902 of the Act [42 U.S.C. § 1396a(a)] and amending Section 1912(a) to the Act [42 U.S.C. § 1396k]). Congress again strengthened the TPL provisions in 1986, with a related Senate Report expressing Congress's intent that "Medicaid is intended to be the payer of last resort." S. Rep. No. 99-146 at 279 (1985), *reprinted in* 1986 U.S.C.C.A.N. 42, 312, Pet. App. 44.

In 1993, Congress again amended the Act to add subsection (H) to 42 U.S.C. § 1396a(a)(25), which mandates that states have in effect laws under which they are considered to have acquired the rights of recipients to payment by any third party who is legally liable for the recipients' medical costs "to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished." *See* P.L. 103-66, § 13622(c) (adding subsection (H) to Section 1902(a)(25) of

the Act [42 U.S.C. § 1396a(a)(25)(H)]). It is instructive that in that same legislation, Congress likewise made changes to the anti-lien provision but took no action that would suggest an intention to exclude any portion of a third party recovery from the scope of Medicaid's right to reimbursement. *See* P.L. 103-66, §§ 13611, 13622 (amending Sections 1917(b)-(e) of the Act [42 U.S.C. § 1396p(b)-(e)]).

Furthermore, because the Act requires that an individual assign to the State as a condition of Medicaid eligibility her right to "payment for medical care from any third party" liable for those expenses, 42 U.S.C. § 1396k(a)(1)(A), a Medicaid recipient no longer retains a property interest in the monies assigned. Rather, those monies become the property of the Medicaid program by operation of the assignment, and any lien placed upon them is not being placed upon property of the recipient, thus rendering the anti-lien provision irrelevant. This sound reasoning has been adopted by several courts, including the district court below. *See Wilson v. State*, 10 P.3d 1061, 1063 (Wash. 2000), *cert. denied*, 523 U.S. 1020 (2001); *Houghton v. Department of Health*, 57 P.3d 1067, 1069 (Utah 2002), *cert. denied*, 538 U.S. 945 (2003); *Cricchio v. Pennisi*, 683 N.E.2d 301, 305 (1997) and *Calvanese v. Calvanese*, 710 N.E.2d 1079, 1081-82 (N.Y. 1999), *cert. denied*, 528 U.S. 928 (1999). *But see Martin v. City of Rochester*, 642 N.W.2d 1, 13-14, 19 (Minn. 2002), *cert. denied*, 539 U.S. 957 (2003) (based upon federal third party liability statutes, state has assignment rights to "all proceeds for *medical care*, but does not have rights in any other part of recovery") (court's emphasis).

In *FDA v. Brown & Williamson Tobacco Corp.*, this Court recognized that due to the "fundamental cannon of statutory construction that the words of a statute must be

read in their context and with a view to their place in the overall statutory scheme," a court must "interpret the statute as a symmetrical and coherent regulatory scheme," and "fit, if possible, all parts into a harmonious whole." 529 U.S. 120, 133 (2000) (citations and internal quotations omitted). There is nothing in the anti-lien provision that reflects a Congressional intent to insulate any portion of a recipient's settlement with a liable third party from Medicaid recovery in the manner suggested by the court of appeals. Rather, a review of the overall statutory scheme of the Act reflects Congress's desire to replenish the Medicaid program by demanding full recovery from third parties who trigger program expenditures.[8]

Consistent with the federal TPL provisions, Arkansas law requires that applicants for Medicaid benefits must, "[a]s a condition of eligibility . . . automatically assign his or her right to any settlement, judgment, or award which may be obtained against any third party to [the Department] to the full extent of any amount which may be paid by Medicaid for the benefit of the applicant." Ark. Code Ann. § 20-77-307(a). It further provides that "[t]he assignment shall be considered a statutory lien on any settlement, judgment, or award received by the recipient from a third party." Ark. Code Ann. § 20-77-307(c). Thus, under Arkansas law, the lien does not attach to the recipient's "property" because it attaches only to those proceeds already assigned to the Department as a condition of Medicaid eligibility.

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[8] The third party liability recovery statutes do not apply only to tortfeasors, but likewise apply to reimbursement from third parties such as "health insurers, group health plans . . . and health maintenance organizations." 42 U.S.C. § 1396a(a)(25)(A).

B. Arkansas's Third Party Assignment and Recovery Laws, Which Were Enacted In Compliance With The Federal TPL Provisions, Do Not Violate The Federal Anti-Lien Provision

The court of appeals erred in concluding that Arkansas law runs afoul of the federal anti-lien provision. Initially, the court correctly recognized that the federal TPL provisions mandate that states require Medicaid applicant to assign some portion of third party settlement recoveries as a condition of Medicaid eligibility, and did not suggest that this federal assignment mandate was inconsistent with the anti-lien provision. Pet. App. 9, 10. For the reasons stated above, the court erred, however, in finding that these statutes are "limited to rights to third-party payments made to compensate for medical care." Pet. App. 10. Stated differently, the court of appeals concluded that the federal TPL provisions mandate that states require a Medicaid applicant to assign to the State Medicaid program *only* her right to payments from liable third parties that are designated as or represent payment for medical costs. This erroneous narrowing of the federal provisions thus tainted the court's view of the State's assignment and recovery provisions, resulting in the mistaken conclusion that Arkansas law overreached by demanding an assignment "to the full extent" of the amount paid by Medicaid for the benefit of the recipient. Had the court of appeals recognized the proper scope of the assignment mandate under federal law, it necessarily would have found that Arkansas's assignment provision was consistent with the federal law and thus not "pre-empted" by the federal anti-lien statute.

Next, the court of appeals erred in finding that Arkansas's assignment and recovery provisions forced Ahlborn to assign her unliquidated tort claim or "chose in action," as well as her "right to sue for damages," both of which the court deemed "property" under State law. The court failed to recognize, however, that Arkansas law did *not* require Ahlborn to assign her claim or her right to sue. To the contrary, Arkansas's assignment and recovery provisions expressly provide that a Medicaid recipient may prosecute her action "alone," Ark. Code Ann. § 20-77-302, with the only limitation being that "any settlement, judgment, or award obtained is subject to the [Department's] claim for reimbursement." Ark. Code Ann. § 20-77-302(a). Likewise, if the Department brings an action against a third party to recover medical assistance benefits paid to a recipient by the State Medicaid program, the law provides that "[n]o action taken on behalf of the [Department] . . . or any judgment rendered in the action shall be a bar to any action upon the claim or cause of action of the recipient . . . against the third person who may be liable for the injury," "[n]or shall any action [by the Department] operate to deny to the recipient the recovery for that portion of any damages not covered hereunder." Ark. Code Ann. § 20-77-301(b). Thus, Arkansas law does not authorize the Department to block a settlement or to overtake a recipient's personal injury cause of action; it merely enables the Department to recover from a liable third party the cost of the recipient's medical care paid for by the Medicaid program.

Additionally, the court of appeals failed to recognize that the federal TPL provisions and the compliant Arkansas law *do not* authorize the Medicaid program to seek reimbursement for medical costs paid by the program

unless those costs were caused by a liable third party. For example, if a Medicaid beneficiary wins the lottery or comes upon a large reward, the anti-lien provision would prohibit the program from placing a lien on those monies, regardless of the amount of benefits that the program had paid on the recipient's behalf.[9] Likewise, if Medicaid paid for a recipient's medical care that was *not* caused by a liable third party (e.g., annual preventive examinations, a fracture unrelated to a tortfeasor's conduct) in addition to medical care that was caused by a third party, the program could recover *only* those medical costs caused by the third party.[10] Like lottery winnings, medical costs unrelated to a liable third party's conduct would be a recipient's "property" protected by the anti-lien provision.

Next, the court of appeals incorrectly held that Arkansas law is adverse to the anti-lien provision because "the lien arises *after* Ahlborn receives her settlement from the tortfeasor." Pet. App. 6. In reaching this conclusion, the court turned to the language in Ark. Code Ann. § 20-77-307(c), which provides: "[t]he assignment shall be considered a statutory lien on any settlement, judgment, or award *received by the recipient from a third party.*" *Id.* Such a hyper-technical interpretation of the word "received" would be inconsistent with the purpose of both the state and federal TPL provisions, which is that Medicaid be reimbursed for medical expenditures made on behalf of recipients from the funds of third parties who are responsible for those

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[9] Of course, this increase in resources might disqualify the recipient from receiving future Medicaid benefits.

[10] In fact, it was for this reason that a downward adjustment was made to the amount that the State Medicaid program sought from Ahlborn. *See* Pet. App. 18, n.2.

expenditures. It is a fundamental principle of statutory construction "that the meaning of a word [not] be determined in isolation, but must be drawn from the context in which it is used." *Deal v. United States*, 508 U.S. 129, 132 (1993) (citations omitted).

Even if a Medicaid recipient does at some point in time have settlement proceeds in her possession, any portion of those proceeds that she previously assigned to the Department as a condition for Medicaid eligibility *is not her property.* Under Arkansas law, the Medicaid recipient is holding any such funds tendered directly to her in "constructive trust," which arises when a person holding property has an equitable duty to convey it to another. *See Waterall v. Waterall*, 155 S.W.3d 30, 33 (Ark. App. 2005). This duty to convey property arises when, among other situations, there has been a "wrongful disposition of another's property." *Id.* In fact, in the present case insurance carriers tendered $50,000.00 *directly* to Ahlborn. If one accepted the reasoning of the court of appeals that the anti-lien provision insulates a settlement recovery once it is placed in a recipient's hands, the Medicaid program would be rendered powerless in the present case to obtain reimbursement from any portion of this $50,000.00, *regardless* of Ahlborn's assignment.

Finally, for the reasons discussed below, the court's refusal to defer to the Secretary's interpretation of the Act was likewise erroneous.

II. The Secretary's Adjudications And Interpretations Addressing Medicaid, Which Is "A Complex And Highly Technical Regulatory Program," Are Entitled To Deference And Respectful Consideration

Although the plain language of the federal TPL provisions support the conclusion that Medicaid is entitled to full reimbursement from the settlement proceeds paid by a liable third party who caused the need for a recipient's medical care, Congress included nothing in the statutory text that speaks directly to how these provisions are to be implemented in the context of a compromise settlement. Any arguable ambiguity as to how these provisions intersect with the anti-lien provision presents the very type of "complex and highly technical" issue that the Congress has granted the Secretary "exceptionally broad authority" to address. *Wisconsin Dep't of Health & Family Services v. Blumer*, 534 U.S. 473, 497 (2002) (citations omitted).

Formal federal agency adjudications, such as those issued by Departmental Appeals Board ("Board") of the United States Department of Health and Human Services, are granted full deference when the language of a statute is ambiguous or silent on a particular issue and the interpretation is a permissible construction of the statute. *United States v. Mead Corp.*, 533 U.S. 218, 229 (2001) (citations omitted); *Chevron U.S.A. Inc. v. Natural Resources Defense Council*, 467 U.S. 837, 843 (1984). Agency interpretations not contained in regulations or adjudications, although not due the same degree of deference, are nonetheless due a "respect proportional to [their] 'power to persuade'" given the "'specialized experience and broader investigations and information' available to the agency." *Mead Corp.*, 533 U.S. 234-35 (*quoting Skidmore v. Swift & Co.*, 323 U.S. 134,

139-40 (1944)); *Wisconsin Dep't of Health & Family Services v. Blumer*, 534 U.S. 473, 497 and n.13 (2002).

A. The Departmental Appeals Board's Rulings That The Medicaid Program Is Entitled To Full Reimbursement Are Entitled To *Chevron* Deference.

In *United States v. Mead Corp.*, this Court recognized that a court should accord deference to an agency adjudication "when it appears that Congress delegated authority to the agency generally to make rules carrying the force of law, and that the agency interpretation claiming deference was promulgated in the exercise of that authority." 533 U.S. at 226-27. Such a delegation may be shown "in a variety of ways, as by an agency's power to engage in adjudication or notice-and-comment rulemaking." *Id.* at 227. In 42 U.S.C. § 1302(a), Congress authorized the Secretary to "make and publish such rules and regulations, not inconsistent with the [Social Security Act], as may be necessary to the efficient administration of the functions with which [it] is charged under [the] Act." This Court has "long noted Congress' delegation of extremely broad regulatory authority to the Secretary in the Medicaid area." *Wisconsin Dep't of Health & Family Services v. Blumer*, 534 U.S. 473, 497, n.13 (2002).

The Secretary has interpreted the operation of the federal TPL provisions in the context of third party settlements through formal adjudications by the Departmental Appeals Board ("Board").[11] Although the federal anti-lien

[11] The Board's basic process is to review a written record that both parties are "given ample opportunity to develop," which process may be

(Continued on following page)

provision was not directly at issue in these cases, it has been present in relevant part in the Act since 1965, thus leading to the reasonable conclusion that the Board was aware of the entire body of the Medicaid law at the time it rendered these decisions. Furthermore, the Board's reasoning transfers readily into the present context, as it reflects the broad scope of the federal TPL provisions.

In *California Dep't of Health Services*, HCFA (CMS's predecessor) had opposed California's practice of permitting recipients to keep portions of third party recoveries regardless of whether Medicaid was first fully reimbursed. DAB No. 1504, 1995 WL 66334 (Dep't of Health & Human Services, January 5, 1995), Pet. App. at 68, 69. The Board upheld HCFA's interpretation, concluding that federal Medicaid law requires full Medicaid reimbursement before a recipient may collect any proceeds from a third party settlement. App. at 69, 75. In so ruling, the Board concluded that HFCA's position was "directly supported" by the Act, explaining:

> [r]ecipients, as a condition of eligibility, must assign their rights to payment for medical care. States are then charged with the responsibility of seeking third party recovery pursuant to such assignments. States are further required to seek as much reimbursement as possible, i.e., to the extent of the third party's liability. Finally, when a recovery is made, the Act sets forth a distribution scheme which requires the Medicaid program to be reimbursed prior to distributing any funds to the recipient. While [42 U.S.C. § 1396k(a)] refers to

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supplemented by informal conferences or a hearing if deemed appropriate. 45 C.F.R. § 16.4 (2005).

> assignment only of "payment for medical care," the statutory scheme as a whole contemplates that the actual recovery might be greater and, if it is, that Medicaid should be paid first.

Pet. App. at 76. The Board also recognized that this position was not unfair to the Medicaid recipients, noting:

> [i]f Medicaid had not paid their medical expenses, these recipients would have both unrestricted access to their settlements and enormous medical debts to be paid from those settlements . . . where Medicaid has incurred the "debt" for recipients, it is not unfair for HCFA to require complete reimbursement from these liability funds.

Pet. App. at 85.

The Board rejected the State of California's argument that by demanding full Medicaid reimbursement for medical costs paid from third party settlement proceeds, HCFA "ignored the fact that these payments included amounts for things other than medical care." Pet. App. 80. The Board reasoned in part that Medicaid law, through the federal TPL provisions, looks to a third party that has caused the need for medical care "to reimburse the public." Pet. App. 80-81. Additionally, it noted that Medicaid recipients had received benefits only on the condition that the program would have a superior status to recover costs from any third party who is liable for those costs. Pet. App. 81. The Board also noted that characterizing recoveries from third parties first as payments for medical care "prevents manipulation of tort awards by recipients who seek to prevent the public from being reimbursed for the funds it has advance for their medical care," and that without such a characterization, "[third party liability]

recoveries would be subject to a wide range of interpretations about what was appropriately considered medical care." Pet. App. 81.

The Board reached a similar result the following year in *Washington State Dep't of Social & Health Services*, again upholding HCFA's determination that the federal TPL provisions mandate that Medicaid be reimbursed in full before a recipient may receive any third party settlement monies. DAB No. 1561, 1996 WL 157123 (Dep't of Health & Human Services, February 7, 1996), Pet. App. 45. The Board explained:

> Where there is a third party that is responsible for paying a recipient's medical expenses, the recipient may not recover money for him/herself until the federal government is reimbursed for its expenditure of the recipient's medical care . . . HCFA may require a state to assert a collection priority over funds obtained by Medicaid recipients in TPL suits even though the distribution methodology set forth in [42 U.S.C. § 1396k(b)] refers only to payments collected pursuant to assignments for medical care.

Id. at Pet. App. 54. Again, the Board stated unequivocally: "In cases where a third party has caused the need for medical care and is liable for its payment, the Act looks to that third party to reimburse the public." *Id.*

The court of appeals erred in not affording deference to these formal adjudications. Such a refusal is contrary to this Court's recognition of "Congress' delegation of extremely broad regulatory authority to the Secretary in the Medicaid area." *Wisconsin Dep't of Health & Family Services v. Blumer*, 534 U.S. 473, 496 n.13 (2002) (citations omitted). These formal adjudications likewise constitute "a

permissible construction of the [TPL] statute[s]," *Chevron*, 467 U.S. at 843, and advance Congress's intention that Medicaid be the "payer of last resort."

B. The Secretary's Interpretations Addressing The Relationship Between The Federal TPL And Anti-Lien Provisions Are Entitled To Respectful Consideration

Additionally, the Secretary (through HCFA/CMS) has repeatedly confirmed that the federal anti-lien provision does not prohibit states from placing liens on third party settlement proceeds to recover for medical assistance payments made by the Medicaid program to a recipient in cases where a liable third party has caused the need for the recipient's medical care. For example, in a letter to the states issued in June of 1988,[12] the HCFA instructed that a Medicaid recipient has a right "only to the remainder" of any recovery from a liable third party "after Medicaid payments are fully reimbursed." HCFA letter entitled "State Third Party Liability (TPL) Subrogation Legislation" (issued June 1, 1988), J.A. 28. Although this letter did not directly address the anti-lien provision, it emphasized HCFA's position that federal Medicaid law "does not authorize any payments to the recipient until Medicaid is fully repaid." J.A. 28. In reaching this conclusion, HCFA soundly reasoned that the federal TPL provisions mandate that a state is entitled to reimbursement for "what it paid

[12] In its Petition for Writ of Certiorari, the petitioner inaccurately indicated that this letter was issued in June of 1998 instead of 1988. This inaccuracy did not affect the reasoning set forth in the Petition, however.

on behalf of the recipient." J.A. 27, 28 (*citing* 42 U.S.C. §§ 1396a and 1396k).

In a letter issued by HCFA in September of 1994, the Secretary directly addressed the relationship between the federal TPL provisions and the anti-lien provision in the context of a recipient's settlement with or judgment against a liable third party. HCFA letter entitled "Third Party Liability Relationship to Liens" (issued September 2, 1994), J.A. 31-32. At bottom, HCFA noted that although federal law prohibits a state "from imposing liens against the property of an individual prior to his/her death because of medical assistance paid on his/her behalf," states are nonetheless required by the federal TPL provisions to seek reimbursement from a liable third party "for medical assistance payments already made" by the Medicaid program. J.A. 31. Recognizing that a recipient assigns to the state as a condition of Medicaid eligibility her rights to payment from any third party and likewise must cooperate with the state in the pursuit of any third party who might be liable for payment, HCFA explained that the state has a "claim to the amount recovered by [a] recipient" in a legal action against a third party "even though [the state] may not have been a party to the litigation." J.A. 32.

Specifically addressing the anti-lien provision, HCFA explained:

> If, under State law, a lien is not being placed upon the Medicaid recipient's property, but rather is being placed upon the tortfeasor's (the defendant in the personal injury litigation) property or upon funds which are set aside to be used in a settlement of the litigation, but which have not become the recipient's property, then there

> would be no conflict with [the anti-lien provision].
>
> . . .
>
> [states] have an interest in the potential personal injury settlement when a recipient's right to recover payment for medical care must have been assigned to [the state] . . . in order for him/her to be eligible for Medicaid. In that event, if you place a lien on these funds, it does not violate the [federal anti-lien] statute. However, you may not impose a lien on any of the recipient's property which has not been assigned to you.

J.A. 32.

The Secretary reiterated this position in a HCFA letter issued in June of 1996. HCFA letter entitled "Treating Disability Trusts Under Transfer Of Assets, Trust, Estate Recovery, and Third Party Liability Rules – INFORMATION (issued June 6, 1996), J.A. 31-32. In large part, the letter dealt with tightening of eligibility rules governing the use of trusts by Medicaid applicants. HCFA took this opportunity to once again expressly recognize a state's duty "to seek reimbursement for medical assistance payments already made," as well as a recipient's duty of cooperation in this regard and her initial assignment of rights as a condition of Medicaid eligibility. J.A. 36-37. Addressing the anti-lien provision, HCFA explained:

> If State laws permit, a State can place a lien upon a third party's property, as in a situation involving the property of a tortfeasor or defendant in a personal injury suit, or upon funds which are set aside to be used in a settlement, but which have not yet become the property of the Medicaid applicant or recipient.

> [the anti-lien provision] precludes States from placing liens on individual's property. However, because a potential personal injury settlement is not yet the plaintiff's property, it can be subject to a TPL lien.

J.A. 37-38.

This Court has long recognized that informal policy interpretations by an agency charged with the administration of a statute are entitled to some level of deference as long as they are informed, reasonable, and persuasive. *See Skidmore v. Swift & Co.*, 323 U.S. 134, 140 (1944); *see also Christensen v. Harris County*, 529 U.S. 576, 587 (2000); *United States v. Mead Corp.*, 533 U.S. 218, 227-35 (2001). Policy statements and guidelines addressing the administration of a federal program, "while not controlling upon the courts by reason of their authority, do constitute a body of experience and informed judgment to which courts and litigants may properly resort for guidance." *Skidmore*, 323 U.S. at 140. "[A]n agency's interpretation may merit some deference whatever its form, given the 'specialized experience and broader investigations and information' available to the agency," and "given the value of uniformity in its administrative and judicial understandings of what a national law requires." *Mead Corp.*, 533 U.S. at 234 (*citing Skidmore*, 323 U.S. at 139-40).

In *Wisconsin Dep't of Health & Family Services v. Blumer*, this Court addressed the level of deference accorded to interpretations of the United States Secretary of Health and Human Services in the context of the Medicaid program. 534 U.S. 473 (2002). In *Blumer*, this Court held that Wisconsin's use of an "income first" method, which the Secretary had specifically authorized in a "Regional State Letter," was a permissible approach under federal

law for determining an institutionalized spouse's Medicaid eligibility. Upholding the State's method, this Court found that the Secretary's position warranted "respectful consideration," which it found was "particularly appropriate" within the Medicaid context due to the Secretary's "significant expertise" in "a complex and highly technical regulatory program." *Id.* at 497 (citations omitted). In so ruling, this Court also recognized the long-standing principle that Congress delegated "extremely broad regulatory authority to the Secretary in the Medicaid area." *Id.* at 497 n.13. (citations omitted).

The court of appeals erred in refusing to afford any value to the view of the Secretary that the federal anti-lien provision does not prohibit states from placing liens on third party settlement proceeds to recover medical assistance payments made by the Medicaid program to a recipient. The Secretary's reasoning is persuasive and well-grounded in the plain language of the federal TPL and anti-lien statutes. Additionally, the legislative history strongly supports the persuasiveness of this view, considering that Congress intended Medicaid to be the "payer of last resort."

III. Full Reimbursement Of The Medicaid Program Is Preferable From A Policy Standpoint

Sound policy considerations likewise militate in favor of full Medicaid reimbursement in the third party liability context. This is particularly true at a time when the level of federal funding of the Medicaid program is decreasing. Full program reimbursement is not only mandated by the federal TPL provisions, but also will enhance the fiscal viability of the program. Medicaid dollars are far from

being an endless resource, and money reimbursed to the program from liable third parties may be used to aid other Medicaid applicants in need.

First, the position advanced by the court of appeals would place the Medicaid program in the untenable position of being treated less favorably than for-profit health care providers. If a person who is not receiving Medicaid benefits is injured by a third party, that individual remains liable to his or her medical providers for the full amount of medical services provided. Any interpretation of the TPL and anti-lien provisions that would allow a Medicaid recipient to receive medical care at public expense and subsequently keep funds recovered from a third party who triggered those costs – as opposed to having those funds returned to the Medicaid program and thus the taxpaying public – is antithetical to Congress's intent that Medicaid be the payer of last resort.

For example, assuming *arguendo* that Ahlborn had not applied for Medicaid benefits but rather had accumulated medical costs at or near $215,645.30 as a result of her accident, she would be obligated to reimburse her medical providers for that *entire amount* from any settlement proceeds. There is absolutely no reason why she should not have to likewise reimburse the Medicaid program. In enacting the TPL and anti-lien provisions, Congress surely did not intend that Medicaid receive such disparate, unfavorable treatment, nor did it intend that the recipient receive a windfall at the expense of other Medicaid applicants and the taxpaying public. Moreover, as the Departmental Appeals Board recognized in *California Dep't of Health Services*, a requirement that the Medicaid program be completely reimbursed from settlement proceeds is not unfair to recipients because, "[i]f

Medicaid had not paid their medical expenses . . . recipients would have both unrestricted access to their settlements and enormous medical debts to be paid from those settlement proceeds. As Medicaid recipients, they do not have such debts because the public has paid their medical expenses." DAB No. 1504, 1995 WL 66334 (Dep't of Health & Human Services, January 5, 1995), Pet. App. at 68, 85.

Second, it is incongruous to argue on one hand that Ahlborn's resources were so limited at the time of her accident that she qualified for publicly funded medical benefits for the "needy," but on the other hand that she retained a property interest – insulated from the federal TPL reimbursement mandate – in those portions of a personal injury settlement that she and a third party designate as or consider to be something other than recovery for medical care. Such an argument creates "an anomalous situation in which Medicaid applicants could be disqualified from eligibility for financial resources that include prior personal injury settlements allocated to pain and suffering, but Medicaid recipients could shield such funds from recoupment by the [Medicaid program] after having received significant public assistance." *Calvanese v. Calvanese*, 710 N.E.2d 1079, 1082 (N.Y. 1999), *cert. denied*, 528 U.S. 928 (1999). Ahlborn's argument, which constitutes the proverbial "having your cake and eating it too," ignores the reality that the Medicaid program paid Ahlborn's medical bills and is now merely seeking to be paid back by the third party who caused those costs in the first instance.

Third, Ahlborn's position would force states to intervene in all ongoing litigation or to file independent causes of action against third party tortfeasors to recover Medicaid program expenditures. And as the present case shows,

even intervention does not always lead to satisfactory reimbursement results. Increased state participation in litigation will result in a substantial increase in expenditures of staff time and financial resources by the states. At bottom, requiring states to pursue third parties directly to recover publicly funded medical costs, instead of using lien or subrogation statutes, would force states to spend much more money to recover the same amount of funds, thereby leaving less money to return to the Medicaid program for use by Medicaid applicants in need.

Finally, Ahlborn's approach would promote manipulation in the apportionment of recoveries by the parties. As the district court below correctly reasoned, "adopting the approach advocated by [Ahlborn] would encourage manipulation of the allocation of settlement amounts," and would likewise "place upon States the additional burden of proving up the past medical expense component of a compromise settlement or challenging the allocation made by others with no interest in placing an appropriate value on that component of recovery." Pet. App. 30-31. This concern is shared by the Departmental Appeals Board, which explained in a case involving a Medicaid recipient's settlement recovery from a liable third party:

> HCFA reasonably insisted on its right to characterize recoveries from third parties first as payments for medical care. This characterization prevents manipulation of tort awards by recipients who seek to prevent the public from being reimbursed for the funds it has advanced for their medical care (e.g., by suing for pain and suffering or lost wages rather than for medical costs). Without it, TPL recoveries would be subject to a wide range of interpretations about what

was appropriately considered payment for medical care.

California Dep't of Health Services, DAB No. 1504, 1995 WL 66334 (Dep't of Health & Human Services, January 5, 1995), Pet. App. at 68, 81.[13]

CONCLUSION

For the reasons and based upon the authorities set forth above, the Petitioners respectfully request that the judgment of the court of appeals be reversed.

Respectfully submitted,

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[13] This manipulation concern would be absent if the recipient's claim was tried to a judge or jury that apportioned any recovery between damages for medical costs versus those for non-medical cost elements of the recipient's claim. In the trial context, the fact finder would determine "the extent of [the third party's] legal liability," *see* 42 U.S.C. § 1396a(a)(25)(B), or the amount of "payments for medical care owed to the recipient" by the third party, *see* 42 U.S.C. § 1396k(a). Thus, the Medicaid program would receive from the total recovery the amount awarded for medical costs. If the judge or jury does not apportion damages, however, the federal TPL provisions mandate that the Medicaid program will receive full reimbursement from the total award before the recipient may be paid the remainder. *See* 42 U.S.C. § 1396k(b).

APPENDIX

42 U.S.C. § 1396. Appropriations.

For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this subchapter. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for medical assistance.

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42 U.S.C. § 1302. Rules and Regulations; Impact Analyses of Medicare and Medicaid Rules and Regulations on Small Rural Hospitals.

(a) The Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health and Human Services, respectively, shall make and publish such rules and regulations, not inconsistent with this chapter, as may be necessary to the efficient administration of the functions with which each is charged under this chapter.

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42 C.F.R. § 430.10. The State plan.

The State plan is a comprehensive written statement submitted by the agency describing the nature and scope

of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.

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42 C.F.R. § 433.36. Liens and recoveries.

(a) Basis and purpose. This section implements sections 1902(a)(18) and 1917(a) and (b) of the Act, which describe the conditions under which an agency may impose a lien against a recipient's property, and when an agency may make an adjustment or recover funds in satisfaction of the claim against the individual's estate or real property.

(b) Definition of property. For purposes of this section, "property" includes the homestead and all other personal and real property in which the recipient has a legal interest.

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45 C.F.R. § 16.4. Summary of procedures below.

The Board's basic process is review of a written record (which both parties are given ample opportunity to develop), consisting of relevant documents and statements submitted by both parties (see § 16.8). In addition, the Board may hold an informal conference (see § 16.10). The informal conference primarily involves questioning of the participants by a presiding Board member. Conferences

may be conducted by telephone conference call. The written record review also may be supplemented by a hearing involving an opportunity for examining evidence and witnesses, cross-examination, and oral argument (see § 16.11). A hearing is more expensive and time-consuming than a determination on the written record alone or with an informal conference. Generally, therefore, the Board will schedule a hearing only if the Board determines that there are complex issues or material facts in dispute, or that the Board's review would otherwise be significantly enhanced by a hearing. Where the amount in dispute is $25,000 or less, there are special expedited procedures (see § 16.12 of this part). In all cases, the Board has the flexibility to modify procedures to ensure fairness, to avoid delay, and to accommodate the peculiar needs of a given case. The Board makes maximum feasible use of preliminary informal steps to refine issues and to encourage resolution by the parties. The Board also has the capability to provide mediation services (see § 16.18).